STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155041	A. BUILDING 00 B. WING	09/30/2011

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NORTHWEST MANOR HEALTH CARE CENTER	6440 WEST 34TH STREET INDIANAPOLIS, IN46224

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: September 26, 27, 28, 29, 30, 2011 Facility number: 000015 Provider number: 155041 AIM number: 100273750 Survey team: Rita Mullen, RN, TC Janet Stanton, RN Michelle Hosteter, RN Heather Lay, RN Census bed type: SNF/NF: 103 SNF: 7 Total: 110 Census payor type: Medicare: 32 Medicaid: 58 Other: 10 Total: 110 Sample: 23 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.	F0000	Northwest Manor & Healthcare Center acknowledges receipt of the statement of deficiences and plan of correction does not denote agreement with the statement of deficiences nor does it constitue an admission that the deficiences are accurate.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 10/5/11 Cathy Emswiller RN			
F0242 SS=D	The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure that a resident who had physician orders for a fluid restriction, was allowed to have a choice about what type of fluids she could have, the amount of fluids she could have at a given time, or the how the fluids were to be distributed throughout the day within the restriction. This deficiency impacted 1 of 1 resident reviewed who had a fluid restriction, in a sample of 23. [Resident #13] Findings include: In an interview during the initial orientation tour on 9/26/11 at 10:05 A.M., L.P.N. #1 indicated Resident #13 was in the facility for therapy before returning home. The resident received hemodialysis three days a week, and had a	F0242	Nursing and Dietary have reviewed with Resident #13 fluid restrictions, providing information on the resident's ability to make choices daily on fluid preferences, fluid allocation and interchanging of fluids. Fluid restriction policy and procedure have been revised to include resident preferences when calculating fluid distribution.Currently no other residents having a physician ordered fluid restrictions reside in the facility.Nursing staff will be inserviced on the updated policy/procedure for fluid restriction. This training will include resident's ability to assist with the fluid distribution and preferences of different fluids as well as accurate documentation of fluids consumed orally each shift.Quality Assurance monitoring will be initiated to monitor compliance with fluid restriction policy/procedure. This	10/30/2011

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	restriction of fluids to a total amount of 1500 ml./cc. [milliliters/cubic centimeters] in a 24-hour period. The nurse indicated the resident was alert, oriented, and interviewable. The clinical record for Resident #13 was reviewed on 9/29/11 at 10:40 A.M. Diagnoses included, but were not limited to, chronic kidney disease with hemodialysis, diabetes, hypertension, and congestive heart failure. The quarterly M.D.S. [Minimum Data Set] assessment, dated 8/5/11, indicated the resident had a BIMS [Brief Interview for Mental Status] score of "15" [a score of 13-15: cognitively intact]. The October, 2011 Physician Order recap [recapitulation] sheet listed orders which included: 5/12/11--Nepro [a dietary supplement drink for people with kidney impairments], "Give 237 ml. (1 can) by mouth three times a day with meals;" 5/11/11--1500 ml./24 hours fluid restriction. The September, 2011 "Fluid Restriction" form, located in the M.A.R. [Medication Administration Record], indicated the following: "90 cc with 6:00 A.M. medication pass.		monitoring will be completed weekly times six, monthly times 3, then quarterly with reports to the Quality Assurance Committee. QA monitors will be completed by nurse managers. Overall compliance will be monitored by the DON and Administrator.	

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	Additional 240 cc. with breakfast. [240 cc. in addition to the Nepro 237 cc.] Additional 180 cc. with lunch and dinner. [180 cc. in addition to the Nepro 237 cc.] 90 cc. with H.S. [bedtime] medication pass." In an interview on 9/29/11 at 1:25 P.M., resident # 13 indicated no one in the facility had ever spoken with her about her fluid restriction. She said "I kinda know how it works," but was never asked how she wanted the fluids that were allowed distributed throughout the day. The resident indicated she got all of the fluids allowed on each of the three meal trays, and none in between meals. Resident #13 indicated she liked coffee, and got that on her breakfast tray. She also said "I dearly love pop," and would "really like to have some pop in the afternoon or evening." She indicated she was knowledgeable about the type of pop that could be allowed--"the clear kind." The resident indicated none of the staff had ever offered her a choice to have a soda pop. In an interview on 9/29/11 at 1:50 P.M., L.P.N.s #1 and #2 indicated the fluid restriction was established by the dialysis agency, that the resident got 90 cc. with her medications in the morning and at bedtime, got the remainder of the fluids			

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	divided among each of the three meals, and was offered a choice of fluids on her meal trays. They indicated the resident did not get a choice of fluids at any other time--"she never asked." They indicated staff had never offered fluids at times other than meals. 3.1-3(u)(3)			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review, observation and interview, the facility failed to update care plan for 1 of 6 residents with falls in a sample of 23 residents reviewed.	F0279	Resident #98 care plan for falls has been reviewed and updated. Bed and chair alarms were initiated. Resident #98 was discharged home on October 8, 2011. Reivew of current	10/30/2011

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	[Resident #98]. Findings include: Record review for Resident #98 was done on 9/26/11 at 1:10 P.M. Diagnoses included, but were not limited to, mild cognitive impairment, depression, diabetes mellitus. The resident was admitted 7/21/11 due to an ankle fracture related to a fall at home. The resident was receiving physical therapy. The resident had falls without injury on September 14th, 17th,19th, and 24th. The care plan dated 7/28/11 indicated, "...maintain resident environment free of clutter and safety hazards, place items frequently used by resident within easy reach, Therapy as ordered, Monitor for unsafe actions and intervene as needed..." The care plan had a handwritten date on it of 9/14/11. "...Recliner removed from room to provide more space, Education on placing boot and attempts to self transfer, Encourage Res[sic] to call for assistance with transfers..." In an interview on 9/27/11 at 10:43 A.M. regarding patients with poor safety awareness skills, the DON indicated the staff would keep the door open and check on the patient regularly if they had not had previous problems getting out of bed		residents having a fall in the last 30 days (Sept 8 - Oct 8) care plan to ensure care plans were updated with appropriate interventions.Nurses will be inserviced on reviewing and updating care plan interventions for residents having fall related incidents.Quality Assurance monitor will be initiated for monitoring compliance with care plan interventions being updated after resident fall related incidents. This QA monitor will be completed weekly for six weeks, monthly times three then quarterly with reports to the QA committee. Monitors will be completed by nurse managers. Overall compliance will be monitored by the DON and Administrator.	

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	unassisted and without alarms. An observation was made on 9/27/11 at 10:45 A.M. with the DON [Director of Nursing] present of the resident in her room in bed with the door shut. The DON at this time talked with the resident and asked if she had shut her door. The resident indicated she had closed the door and further indicated she likes to have it cracked just a little so people walking by can peek in because they like to do that. An observation on 9/27/11 at 1:30 P.M. showed Resident #98's door was closed. An observation on 9/29/11 at 9:30 A.M. showed Resident #98's door was closed. In an interview with the DON [Director of Nursing] on 9/27/11 at 11:20 A.M., she provided a handwritten timeline she had prepared regarding Resident #98's falls. The timeline indicated the following information, "9/24/11 10:45 pm Found Sitting on floor-attempting to get clothing from a drawer-Enc[encourage] to use call lt[light] 9/14/11-12 AM Transferring Unassist from bed, forgot to fasten her boot, tangled up +fell. Intervention: Eliminate some room clutter. 9/19/22-12:45 AM -Up in room unassist[sic] attempting to move w/c			

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	[wheelchair]-nurse came in +[and] moved chair- pt [patient] sat [arrow down] and fell onto buttock- "knee gave out" Discussed Bed/Chair alarm. pt would disable and remove-Family meeting scheduled to discuss safety issues- on therapy." DON indicated the interventions were provided for the falls, the encouraging of call light on 24th, the elimination of room clutter on the 14th, and on the 19th the discussion of the bed alarm and the family meeting. She indicated she did not provide information from the 17th fall as she was not aware she had fallen at that time. She indicated that they did not attempt the chair or bed alarms due to the patient's refusal and the interdisciplinary's team thought that she would disable. 3.1-35(a)			
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure	F0323	Resident #98 care plan for falls was reviewed and revised.	10/30/2011

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	the environment remained free of hazardous chemicals and to put fall interventions in place for 1 of 6 residents reviewed for falls. [Resident#98] The unsecured chemicals on Wing 2 had the potential to affect 17 residents with confusion. Findings include: 1. Record review for Resident #98 was done on 9/26/11 at 1:10 P.M. Diagnoses included, but were not limited to, mild cognitive impairment, depression, diabetes mellitus. The resident was admitted 7/21/11 due to an ankle fracture related to a fall at home. The resident was receiving physical therapy. During the initial tour on 9/26/11 at 9:55 A.M. with LPN #4 she indicated Resident #98 came in after a fall with fracture to her right ankle at home. She indicated that the resident had fallen recently this past weekend. In an interview with the DON on 9/27/11 at 10:43 A.M., she indicated when someone has exhibited poor safety awareness skills, it would be expected that if they had gotten out of bed unassisted before and did not have alarms that they would keep the door open and check on the patient often.		Additional intervention of personal alarms to bed and chair. Staff strongly encouraged Resident #98 to leave her door open. Resident #98 chose to continue keeping her door closed. Staff continued to monitor her. Resident #98 discharged to home on 10/8/11.Chemicals found on Wing 2 were immediately secured. Environmental check of all units to ensure chemicals were properly stored.Staff will be inserviced on the storage of chemicals. Nurses will be inserviced on updating of fall care plans timely.Quality Assurance monitor will be implemented to ensure compliance with proper storage of chemicals. This monitor will be completed weekly for six weeks, monthly for three months then quarterly with reports to the QA committee. This monitor will be completed by the housekeeping supervisor. Overall compliance will be monitored by the DON and the Administrator.Quality Assurance monitor will be implemented to monitor compliance with timely updating of Care Plan interventions when fall related incidents occur. This monitor will be completed weekly for six weeks, monthly for three months then quarterly with reports to the QA committee. Monitors will be completed by nurse managers. Overall compliance will be monitored by the DON and the Administrator.	

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In an interview on 9/27/11 at 10:43 A.M. regarding patients with poor safety awareness skills, the DON indicated the staff would keep the door open and check on the patient regularly if they had not had previous problems getting out of bed unassisted and without alarms.

An observation was made on 9/27/11 at 10:45 A.M. with the DON [Director of Nursing] present of the resident in her room in bed with the door shut. The DON at this time talked with the resident and asked if she had shut her door. The resident indicated she had closed the door and further indicated she likes to have it cracked just a little so people walking by can peek in because they like to do that.

In an interview with LPN # 4 she indicated the resident had been shutting her door more frequently this last week since her roommate passed away.

An observation on 9/27/11 at 1:30 P.M. showed Resident #98's door was closed.

An observation on 9/29/11 at 9:30 A.M. showed Resident #98's door was closed.

The resident had falls without injury on September 14th, 17th,19th, and 24th. The care plan dated 7/28/11 indicated,

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"...maintain resident environment free of clutter and safety hazards, place items frequently used by resident within easy reach, Therapy as ordered, Monitor for unsafe actions and intervene as needed..." The care plan had a handwritten date of 9/14/11 on it and indicated, "...Recliner removed from room to provide more space, Education on placing boot and attempts to self transfer, Encourage Res[sic] to call for assistance with transfers..."

The resident's record indicated on 8/11/11 per social service's assessment with the mini- mental assessment [a tool to measure cognitive ability] that she was mildly cognitively impaired and couldn't remember if she had breakfast or not. The resident was assessed by speech therapy at the facility. According to her plan of treatment dated 8/21/11, "...Development of cognitive skills to improve attention, memory, problem solving and compensatory training...occasional direction needed, difficulty with memory..." These comments related to the resident's memory functioning.

In an interview with the DON on 9/28/11 at 11:20 A.M., she provided her prepared handwritten timeline regarding Resident #98's falls. The timeline indicated the following information, "9/24/11 10:45 pm

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	Found Sitting on floor-attempting to get clothing from a drawer-Enc[encourage] to use call lt[light] 9/14/11-12 AM Transferring Unassist from bed, forgot to fasten her boot, tangled up +fell. Intervention: Eliminate some room clutter. 9/19/22-12:45 AM -Up in room unassist attempting to move w/c [wheelchair]-nurse came in + moved chair- pt [patient] sat [arrow down] and fell onto buttock- "knee gave out" Discussed Bed/Chair alarm. pt would disable and remove-Family meeting scheduled to discuss safety issues- on therapy." DON indicated the following interventions were provided for the falls: the encouraging call light usage on the 24th, the elimination of room clutter on the 14th, and the discussion of the bed alarm and the family meeting on the 19th. She indicated she did not provide information from the 17th fall as she was not aware the resident had fallen at that time. She indicated they did not attempt the chair or bed alarms due to the patient's refusal and the interdisciplinary's team thought she would disable them. 2. On 9/26/2011 at 10:00 A.M., tour of the facility [Wing 2] was initiated with Registered Nurse [RN] #3. At that time, RN #3 indicated that 17 of 37 residents on Wing 2 were "Not Interviewable."			

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	Environmental tour was initiated on 9/27/11 at 8:45 A.M. with the facility Administrator, Assistant Administrator, Maintenance Supervisor, and Housekeeping #1. During tour, housekeeping chemicals were found on a storage container located outside of a resident's room on wing 2 without supervision or housekeeping staff . The two chemicals found were "Dispatch Wipes" and "Disinfectant Spray." At that time, in an interview, the facility administrator indicated staff knew housekeeping materials should not be left in resident areas unsupervised. The "Dispatch Wipes" container indicated "Caution: Keep out of reach of children" and the "Disinfectant Spray" bottle indicated "Caution: Keep out of reach of children." On 9/28/11 at 8:30 A.M., material safety data sheets [MSDS] were received from the Director of Nursing [DoN]. The MSDS for the "Dispatch Wipes" included, but was not limited to, "May be fatal if swallowed..." and the MSDS for the "Disinfectant Spray" included, but was not limited to, "Harmful if absorbed			

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	through the skin..." 3.1-45(a)(1)			
F0327 SS=D	The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on interview and record review, the facility failed to accurately track and monitor the actual fluid amounts consumed by a resident who had restriction of fluid intake to 1500 ml./cc. [milliliters/cubic centimeters] in a 24-hour period. This deficiency impacted 1 of 1 residents reviewed who was receiving hemodialysis and had a fluid restriction, in a sample of 23 residents reviewed. [Resident #13] Findings include: In an interview during the initial orientation tour on 9/26/11 at 10:05 A.M., L.P.N. #1 indicated Resident #13 was in the facility for therapy before returning	F0327	Resident #13 was assessed for adequate hydration to include recent labs and documentation by dialysis center. Based on these findings, Resident #13 was adequately hydrated.No other residents currently residing in the facility with physician ordered fluid restrictions.Nurses have been inserviced on fluid restrictions, accurate documentation, fluid distribution per resident preferences.Quality Assurance monitor will be completed to ensure accurate documentation of fluids taken each shift. This QA monitor will be completed weekly for six weeks, monthly for three months then quarterly with reports to the QA committee. QA monitors will be completed by nurse managers. Overall compliance will be monitored by	10/30/2011

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	home. The resident received hemodialysis three days a week, and had a restriction of fluids to a total amount of 1500 ml./cc. [milliliters/cubic centimeters] in a 24-hour period. The nurse indicated the resident was alert, oriented, and interviewable. The clinical record for Resident #13 was reviewed on 9/29/11 at 10:40 A.M. Diagnoses included, but were not limited to, chronic kidney disease with hemodialysis, diabetes, hypertension, and congestive heart failure. The quarterly M.D.S. [Minimum Data Set] assessment, dated 8/5/11, indicated the resident had a BIMS [Brief Interview for Mental Status] score of "15" [a score of 13-15: cognitively intact]. The October, 2011 Physician Order recap [recapitulation] sheet listed orders which included: 5/12/11--Nepro [a dietary supplement drink for people with kidney impairments], "Give 237 ml. (1 can) by mouth three times a day with meals;" 5/11/11--1500 ml./24 hours fluid restriction. One Care Plan entry, with onset dated 5/18/11, addressed a problem of "I require fluid restriction due to my disease process. I am receiving dialysis and		the DON and Administrator.	

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	congestive heart failure. I have a 1500 ml./day fluid restriction." The approaches included, but were not limited to, the following: "Follow fluid restrictions per M.D. order. I am to have 1500 ml. fluids daily; Nursing will provide me 900 ml. fluids daily; Dietary will provide me with 600 ml. fluids with my meal trays; ... Document and keep my M.D. aware of non-compliance with fluid restrictions." A second Care Plan entry, with onset dated 5/17/11, addressed a problem of "I have potential for weight loss related to decreased appetite. I have edema and my weight may fluctuate...." The approaches included, but were not limited to, the following: "... Monitor food intake at each meal and record...." The September, 2011 "Fluid Restriction" form, located in the M.A.R. [Medication Administration Record], indicated the following: "90 cc with 6:00 A.M. medication pass. Additional 240 cc. with breakfast. [240 cc. in addition to the Nepro 237 cc.] Additional 180 cc. with lunch and dinner. [180 cc. in addition to the Nepro 237 cc.] 90 cc. with H.S. [bedtime] medication pass." The "Fluid Restriction" form			

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	documentation indicated the resident had "received" 90 cc. for the 11-7/night shift, 900 cc. for the 7-3/day shift, and 510 cc. for the 3-11/evening shift, with a total of 1500 cc. for 24 hours. These amounts were documented for each shift and day from September 1 through September 28, 2011. In an interview on 9/29/11 at 1:50 P.M., L.P.N.s #1 and #2 indicated the amount for the Nepro was "rounded up" to 240 cc. They indicated the dialysis agency put her on the fluid restriction and dictated the total amount allowed. The nurses also indicated that other than the 90 cc. given with medications in the morning and bedtime, all fluids were distributed on the meal trays three times a day. Given the distribution listed on the "Fluid Restriction" form, the resident should have received the following amounts per meal: Breakfast=477 cc. [Nepro=237 cc., and additional 240 cc.] Lunch=417 cc. [Nepro=237 cc., and additional 180 cc.] Supper=417 cc. [Nepro=237 cc. and additional 180 cc.] The "Food Intake Record" form from September 1 through September 28, 2011			

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	indicated the following amounts were "consumed" at each meal: 9/1/11: Breakfast=240; Lunch=180; Supper="refused" [Total=600 cc.] 9/2, 9/3, 9/4, 9/5, 9/6, 9/7, 9/9, 9/10, 9/12, 9/14, 9/16, 9/17, 9/18, 9/19, 9/20, 9/22, and 9/23: Breakfast=240; Lunch=180; Supper=360 [Total=780 cc.] 9/8, 9/11, 9/21, and 9/26/11: Breakfast=240; Lunch=180; Supper=240 [Total=660 cc.] 9/13/11: Breakfast=240; Lunch=240; Supper="refused" [Total=480 cc.] 9/15/11: Breakfast= [indecipherable/unable to read]; Lunch=180; Supper=120. 9/24 and 9/25/11: Breakfast=240; Lunch=360; Supper=360 [Total=960] 9/27/11: Breakfast=180; Lunch=180; Supper=240 [Total=600 cc.] 9/28/11: Breakfast=360; Lunch=180; Supper=240 [Total=780 cc.] In the interview on 9/29/11 at 1:50 P.M., L.P.N.s #1 and #2 indicated that, unless she was "sneaking" fluids at other times,			

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	the resident received fluids only at meal times; all her fluids were provided on her meal trays. They indicated all fluids consumed during the meal should be documented on the Food Intake Record. 3.1-46(b)			
F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation and interview, the facility failed to perform lung assessment before and after a respiratory nebulizer treatment. This affected 1 of 1 resident receiving nebulizer treatments in a sample of 23 residents reviewed. [resident # 89] Findings include: The medication pass was done on 9/27/11 at 8:30 A.M. Resident #89 was receiving the nebulizer respiratory medication Ipratoprium-Albuterol 0.5 mg- 3.0 mg (3 ml) for inhalation QID [four times a day]. LPN #5 indicated the resident had COPD	F0328	Resident #89 has been assessed by the respiratory therapist and remains at baseline with no further recommendations for changes in respiratory treatments.All residents currently receiving nebulizer treatments have been assessed by the respiratory therapist to ensure respiratory condition remains at the baseline and to make recommendations for needed changes in respiratory treatments. Recommendations made by the respiratory therapist will be communicated to the attending physician.Nurses will be inserviced on assessment "pre"	10/30/2011

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	[Chronic Obstructive Pulmonary Disease]. The resident sat up with her head of bed up, and the pulse oximeter [a device that measures the amount of oxygen in the blood] was put on her finger. The resident's heart rate was 89 and her oxygen saturation rate was 91%. LPN #5 at this time took the nebulizer mask out of the plastic bag and put the medication into the inhalation chamber and then placed the mask on the resident and started the treatment. The treatment lasted approximately 15 minutes. After the nebulizer treatment was complete, LPN #5 put the oximeter on the resident's finger and obtained her pulse and oxygen saturation rate again and wrote them down. The nurse washed her hands and proceeded to the next patient to pass their medications. In an interview with LPN #5 on 9/27/11 at 8:46 A.M. she indicated that she checks the pulse and oxygen saturation of the resident before and after treatment but did not mention lung sound assessment. In an interview with the DON [Director of Nursing] on 9/27/11 at the daily conference at 3:40 P.M. she indicated the nurses should listen to lung sounds, check pulse and oxygen saturation rate when doing nebulizer treatments.		and "post" nebulizer treatments. Assessment to include checking oxygen saturation levels, listening to breath sounds and checking heart rate.Quality assurance monitor will be initiated to monitor compliance with assessment "pre" and "post" nebulizer treatments. This monitor will be completed weekly for six weeks, monthly for three months and then quarterly with reports to the QA committee. Monitors will be completed by nurse managers. Overall compliance will be monitored by the DON and Administrator.	

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	A policy obtained on 9/28/11 provided by the DON titled "Aerosol Treatments" dated 9/17/07 indicated, "...Establish a baseline heart rate and lung sounds...After treatment check lungs sounds, assess respiratory rate, heart rate and oxygen saturation levels..." The DON also provided a copy of the worksheet the facility provides to nurses to use during administration of nebulizers to write down their assessments. The worksheet has an area on it to document lung sounds before and after inhalation of medication. 3.1-47(a)(6)			

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F0431 SS=D	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to provide secure storage of medications in a locked medication room. The deficient practice impacted 1 of 3 medication rooms. [Wing 1] Findings include:	F0431	Nurses have been inserviced on securing drugs by keeping med room door locked when not occupied. Facility maintenance will install self locking locks and automatic closers on each med room door.Quality assurance monitor will be initiated to ensure compliance with locking medication rooms. This monitor	10/30/2011

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	Environmental tour was initiated on 9/27/11 at 8:45 A.M. with the facility Administrator, Assistant Administrator, Maintenance Supervisor, and Housekeeping #1. During that time, no facility staff were present at the nurse's station and the medication room was unlocked. Medication in the medication room included, but was not limited to, influenza vaccine and various bottles of insulin. These medications were located in an unlocked medication refrigerator. During interview on 9/27/11 at 3:50 P.M., the Director of Nursing [DoN] indicated that all medication rooms were to be locked when staff were not present at the nurse's station. 3.1-25(m)		will be completed weekly for six weeks, monthly for three months then quarterly with reports to the QA committee. Monitors will be completed by the Nurse Managers. Overall compliance will be monitored by the DON and Administrator.	
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			

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	Based on record review and interview, the facility failed to accurately document a physician ordered discontinue [DC] medication for a resident. The deficient practice impacted 1 of 23 resident's reviewed. [Resident #78] Findings include: Resident #78's record was reviewed on 9/28/11 at 10:00 A.M. She was admitted to the facility on 6/21/11. Diagnoses included, but were not limited to, hypoxemia, chronic obstructive pulmonary disease, and congestive heart failure. Resident #78's "physician's orders" included, but were not limited to, discontinue [DC] orders for Tylenol, potassium, Lasix, and Remeron dated 9/19/11, no time available. Resident #78 did not have a physician's order for the medication Lasix prior to 9/19/11; however, an order for the medication torsemide 40 milligrams [mg] was written on 6/20/11 in the physician's orders. Torsemide 40 mg was DC'd on 9/19/11 on the medication administration record [MAR]. There was no order to DC the medication torsemide 40 mg during record review.	F0514	Resident #78 medication was being administered as the physician intended evidenced by review of medications with the physician on the phone and clarification order dated 9/28/11 as well as reassessment by physician on 10/13/11.Consultant pharmacist report conducted 9/26/11 and 9/27/11 did no note issues with physician orders for other residents residing in the facility.Nurses will be inserviced on taking and transcribing physician orders.Compliance will be monitored monthly by the consultant pharmacist with report of findings to the DON and Administrator. Overall compliance will be monitored by nurse managers, DON and Administrator. Consultant pharmacist report to QA committee quarterly.	10/30/2011

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	In an interview on 9/28/11 at 11:05 A.M. with Registered Nurse [RN] #3 and Licensed Practical Nurse [LPN] #1, they indicated Resident #78 would still be taking the medication torsemide 40 mg because the physician's order indicated to only discontinue the medication Lasix, which the resident had not taken at the facility. LPN #1 contacted the resident's physician for a clarification order. A "physician's orders" dated 9/28/11, no time, included, "Clarification: DC torsemide 40 mg daily as of 9/19/11." 3.1-50(a)(2)			